ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES
150 N. 18TH Ave., Suite 410 •• Phoenix, Arizona 85007
RENEWAL APPLICATION FOR A BEHAVIORAL HEALTH SERVICE AGENCY LICENSE
A.R.S. Title 36, Chapter 4 and A.A.C. Title 20

License #_____ Expiration date _____

I. BEHAVIORAL HEALTH SERVICE AGENCY INFORMATION

Name of behavioral health service agency		
Street address		
City		Zip code
Mailing address		
City	State	Zip code
Phone number	Fax number	
Requested behavioral health service agency **subclasses:** **(listed in R9-20-102.A)**		
The location of each subclass on the behavioral health service agency's premises:		
The behavioral health **services** for which the agency is requesting authorization: **(listed in R9-20-102.B)**		
The population for whom the applicant intends to provide behavioral health services:		
The requested licensed capacity for the behavioral health service agency:		

For an agency that provides inpatients and/or residential behavioral health services:
Number of beds requested for individuals younger than 18 years of age_____ inpatient___residential___

Number of beds requested for individuals 18 years of age or older_____ inpatient___residential___

Number of:

Toilets _____ Sinks _____ Showers _____ Tubs _____

Is the behavioral health service agency a secure facility? ____ Yes ____ No
If yes, the number of beds designated for individuals younger than 18 years of age _____ and the number of beds designated for individuals 18 years of age or older _____.

Is the applicant requesting certification under Title XIX of the Social Security Act for the behavioral health service agency?
_____ Yes _____ No

Is the behavioral health service agency accredited by a nationally recognized accreditation organization?
_____ Yes _____ No
If yes, please include the following information:
Name of accreditation organization: _____.
Dates of the accreditation period MM/DD/YY_____ to MM/DD/YY_____.
If the behavioral health service agency is accredited by the Joint Commission on Accreditation of Health Care Organizations, is the behavioral health service agency accredited under the:
Inpatient hospital standards? ____ Yes ____ No
Community behavioral health standards? ____ Yes ____ No

Does the behavioral health service agency have a contract with a Government entity such as: (please check those that apply)
_____The Administrative Office of the Courts, _____Department of Juvenile Justice,
_____Department of Economic Security, _____Tribal government

Does the behavioral health service agency have a contract with a Regional Behavioral Health Authority?____ Yes ____ No
Please check the applicable boxes.
_____CPSA _____GABHA _____VALUE OPTIONS
_____NARBHA (Cenpatico)

II. OWNER INFORMATION

Owner's name		
Address		
City		Zip code
The owner is a: (check one)	_____Sole proprietorship	_____Partnership
_____Limited liability company	_____Corporation	_____Governmental Agency

Has the person applying for a license or a person with 10% or more business interest in the agency previously held a health care institution license in any state or jurisdiction?
____Yes ____ No If yes, include on a separate sheet of paper:
1. The health care institution's name,
2. The license number, and
3. The dates of licensing.

Has the person applying for a license or a person with 10% or more business interest in the agency had a license to operate a health care institution denied, revoked or suspended?
___Yes ____ No

Has the person applying for a license or a person with 10% or more business interest in the agency had a professional or occupational license, other than a driver's license, denied, revoked or suspended?
____ Yes ____ No

Has the person applying for a license or a person with 10% or more business interest in the agency had civil penalties assessed against a health care institution operated in any state by the person applying for a license or the owner?
____ Yes ____ No

Has the person applying for a license or a person with 10% or more business interest in the agency been convicted, in any state or jurisdiction, of any felony?
____ Yes ____ No

Has the person applying for a license or a person with 10% or more business interest in the agency been convicted, in any state or jurisdiction, of any misdemeanor involving moral turpitude, including conviction for any crime involving abuse, neglect, or exploitation of another?
____ Yes ____ No

If any of the above questions are answered yes, include on a separate sheet of paper for each yes answer:
1. The type of action;
2. The date of the action; and
3. The name and address of the court or entity having jurisdiction over the action.

Statutory agent (or individual designated to accept service of process and subpoenas)

Name	Title
Address	Telephone number

or attach a list of the names, titles, and addresses of the behavioral health service agency's board of directors.

III. GOVERNING AUTHORITY

Name

IV. CHIEF ADMINISTRATIVE OFFICER

Name	Title
Education (list the highest educational degree obtained and any instruction related to the behavioral health service agency subclasses for which licensing is requested)	
Experience (list work experience related to the behavioral health service agency subclasses for which licensing is requested)	

Attach:

1. If applicable, a copy of the articles of incorporation, partnership or joint venture documents, or limited liability documents;
2. A program description required in A.A.C. R9-20-201(A)(2);
3. If applicable, a listing of the agency's branch offices including each branch office's address, hours of operation, and behavioral health services provided at the branch office;
4. A document issued by the local jurisdiction with authority certifying that the facility complies with all applicable local building codes;
5. A copy of a current violation-free fire inspection conducted by the local fire department or the Office of the State Fire Marshall;
6. If the agency is required to have a food establishment license pursuant to 9 A.A.C. 8, Article 1, a copy of the most recent food establishment inspection report for the agency;
7. If applicable, a copy of the behavioral health service agency's accreditation report;
8. A list of each staff member, intern, or volunteer employed or under contract with the behavioral health service agency including:
   a. Whether each staff member is a behavioral health professional, behavioral health technician, or behavioral health paraprofessional;
   b. Each behavioral health professional's occupation or professional license or certification number; and
   c. If applicable, each staff member's fingerprint clearance card number; and
9. An organizational chart showing all behavioral health service agency staff member positions and the lines of supervision, authority, and accountability.
10. Is the proposed health care institution located less than 400 feet of agricultural land?
    _____Yes _____No If yes:
    a. Include on a separate sheet of paper the names and addresses of owners or lessees of any agricultural land less than 400 feet of the proposed health care institution, and
    b. Attach a copy of the written agreement between the health care institution owner and the owner or lessee of agricultural land prescribed in A.R.S. § 36-421(D).

V. SIGNATURES

The application is required to be signed according to A.R.S. § 36-422(B).

(1) If an individual, by the owner of the behavioral health service agency;
(2) If a partnership or corporation, by two of the partners or corporate officers; or
(3) If a governmental unit, the head of the governmental department having jurisdiction.

A.A.C. R9-20-103(A)(1)(a) requires the application to be notarized.

_____	_____
Signature Date	Signature Date
_____	_____
Title	Title
STATE OF_____)	STATE OF_____)
COUNTY OF _____)	COUNTY OF _____)
Subscribed and sworn to before me this	Subscribed and sworn to before me this
_____ day of _____,	_____ day of _____,
by	by
Notary Public	Notary Public
My Commission Expires_____	My Commission Expires_____

For DHS use only: Correct application fee enclosed: _____ Yes _____ No

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Revised 07/15/05

RENEWAL LICENSURE ATTACHMENT

Your facility must be ready for survey in order to consider your application complete. Is the facility ready to be surveyed at the time of your application submittal?

_____ Yes _____ No If NO, please give anticipated date _____

Please indicate the name and credentials of your Clinical Director_____

EMPLOYEE LIST

(Attach Organizational Chart)

Name	Position	**Status –** Specify Full Time, Part Time, Intern, Volunteer, Contract or Consultant	Finger-printing Agency *	Clearance Card Number *	Fingerprint Card Expiration Date *	Professional Licensing Agency	License Number	License Expiration Date

*Personnel providing direct services to clients who are under age 18 must be fingerprinted as per A.R. S. § 36-425.03. This includes all staff members, contract/consultant personnel, volunteers and interns. Submit a copy of the fingerprint clearance card or provide the number and the expiration date on the space provided below. If a clearance card has not been received, please submit a copy of the criminal history affidavit along with a copy of a DPS fingerprint clearance application.

PLEASE NOTE IT IS THE APPLICANT'S RESPONSIBILITY TO NOTIFY THE OFFICE OF BEHAVIORAL HEALTH LICENSING OF ANY CHANGES IN WRITING.